GORDON FAMILY PHARMACY
518 S Broad St., Brevard, NC 28712
PHONE: 828-877-6111
FAX: 828-877-6487
EMAIL: gordonfamilypharmacy@gmail.com

ROCKBROOK CAMP FOR GIRLS
PHARMACY FORM
2023

WELCOME TO GORDON FAMILY PHARMACY. WE LOOK FORWARD TO TAKING CARE OF YOUR CHILD'S PRESCRIPTIONS.

WE WILL DO OUR BEST TO PROCESS PRESCRIPTIONS THROUGH YOUR INSURANCE, BUT PLEASE BE AWARE OF THE FOLLOWING:

SOME INSURANCE COMPANIES DO NOT CONTRACT WITH ALL PHARMACIES.

YOU ARE LIABLE FOR ANY BALANCE NOT PAID BY YOUR INSURANCE.

THERE IS A $ 7.00 FEE WE CHARGE FOR EACH BLISTER PACK. THIS FEE COVERS BLISTER PACK SUPPLIES AND IS NOT COVERED BY INSURANCE.

PLEASE FILL OUT ATTACHED FORM AND SEND IT BACK TO GORDON'S (NOT TO YOUR CHILD'S CAMP) AS SOON AS POSSIBLE. COMPLETED FORMS CAN BE RETURNED VIA MAIL, EMAIL, OR FAX.

WE NEED ALL INFORMATION TO BE SUPPLIED 1 MONTH (4 WEEKS) BEFORE YOUR CHILD'S CAMP SESSION STARTS OR THERE WILL BE A 20.00 LATE FEE.

PLEASE DIRECT ANY QUESTIONS TO AMBER AT (828) 877-6111 OR gordonfamilypharmacy@gmail.com.

PLEASE CONFIRM THERE ARE REFILLS ON ALL PRESCRIPTIONS BEING TRANSFERRED. IF THERE ARE NO REFILLS, YOU WILL NEED TO CALL YOUR PHYSICIAN'S OFFICE AND HAVE A NEW SCRIPT SENT DIRECTLY TO GORDON'S.

KEEP IN MIND THAT INSURANCE COMPANIES MAY NOT PAY FOR EARLY REFILLS. IN THIS CASE, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE BUT WILL BE HAPPY TO PUT IT ON OUR DISCOUNTED GORDON FAMILY PLAN.

SOME OVER THE COUNTER MEDICATIONS MAY NEED TO BE SPECIAL ORDERED FOR YOUR CHILD AND MAY NEED UP TO A WEEK TO SHIP. WE WILL NEED ALL FORMS A MONTH IN ADVANCE TO ACCOMMODATE OVER THE COUNTER MEDICATIONS.

OCCASIONALLY SOME MEDICATIONS MAY NOT BE AVAILABLE DUE TO NATIONWIDE SHORTAGES. IN THIS INSTANCE, WE MAY ASK YOU TO MAIL YOUR CHILD'S MEDICATIONS DIRECTLY TO GORDON'S.

PLEASE ADD GORDON'S PHONE NUMBER TO YOUR CONTACT LIST IN CASE WE NEED TO CONTACT YOU REGARDING YOUR CHILD'S MEDICATIONS.

PLEASE SUPPLY AN ACTIVE CREDIT CARD NUMBER SO WE CAN HAVE BLISTER PACKS DELIVERED TO YOUR CHILD'S CAMP THE FRIDAY BEFORE SESSION STARTS.

AGAIN, PLEASE SEND ALL FORMS ONE MONTH BEFORE SESSION STARTS TO MAKE SURE WE HAVE TIME TO GET THESE BLISTER PACKS ASSEMBLED AND TO AVOID A $20.00 LATE FEE.

THANK YOU FROM GORDON FAMILY PHARMACY.

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CAMP SESSION START DATE: _____ SESSION END DATE: _____
***This form is due 30 days prior to the start of your camp session.

ALL FIELDS ARE REQUIRED

Camper's First and Last Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Camper Drug Allergies:_____

Name of Current Pharmacy _____ Current Pharmacy Phone _____

Insurance Company Name: _____

Name of Policy Cardholder: _____

Address of Cardholder: _____

Cardholder ID # _____ RxGroup # _____

RxBin # _____ RxPCN #_____

List prescription medications to be transferred: _____

_____

Over-the-counter medications needed: _____

PLEASE ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARD TO THIS FORM

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE COST OF ANY MEDICATION NOT COVERED BY MY INSURANCE COMPANY, FOR ANY MEDICATION THE PHARMACY CANNOT GET REIMBURSED FOR, AS WELL AS ANY CO-PAYMENTS, DEDUCTIBLES, AND CHARGES FOR OVER THE COUNTER MEDICATION WHICH I AUTHORIZE TO BE CHARGED DIRECTLY TO MY CREDIT CARD BY GORDON FAMILY PHARMACY. IF I AM SUBMITTING INSURANCE INFORMATION, I AGREE TO AUTHORIZE GORDON FAMILY PHARMACY TO CONTACT MY INSURANCE COMPANY FOR INSURANCE VERIFICATION, BILLING, AND COLLECTIONS FOR MY CHILD'S MEDICATIONS. OUR LICENSED PHARMACY IS HIPPA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE SOLELY MAINTAINED FOR THE PURPOSE OF FILLING PRESCRIPTIONS AND PROCESSING INSURANCE CLAIMS.

Parent/Guardian printed name: _____

Parent/Guardian signature: _____ Date: _____

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PAYMENT AGREEMENT

WE REQUIRE THAT YOU SUBMIT A CREDIT CARD NUMBER TO COVER ALL MEDICATIONS AND THE BLISTER PACKAGING FEE.

OUR PHARMACY DOES NOT ACCEPT AMERICAN EXPRESS

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV# _____

Credit Card Type: _____ Zip Code: _____

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE COST OF ANY MEDICATION NOT COVERED BY MY INSURANCE COMPANY, FOR ANY MEDICATION THE PHARMACY CANNOT GET REIMBURSED FOR, AS WELL AS ANY CO-PAYMENTS, DEDUCTIBLES, AND CHARGES FOR OVER-THE-COUNTER MEDICATION AUTHORIZED TO BE CHARGED. OUR LICENSED PHARMACY IS HIPPA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE MAINTAINED SOLELY FOR THE PURPOSE OF FILLING PRESCRIPTIONS AND PROCESSING INSURANCE CLAIMS AND PAYMENTS.

Parent/Guardian printed name: _____

Parent/Guardian phone number: _____

Parent/Guardian signature: _____ Date: _____

Please return this form (with your insurance information) directly to Gordon Family Pharmacy via Email, FAX, or USMail.

Please feel free to contact Gordon Family Pharmacy with your questions.